STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUI	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	MMC	00	COMPL	ETED
		155237	B. WING			02/09/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			SHELBY ST		
BETHAN	Y VILLAGE NURS	ING HOME			APOLIS, IN 46227		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0000							
	This visit was for State Licensure	or a Recertification and Survey.	F000	0	The creation and submission of this Plan of Correction does not constitute an admission by this	ot	
	Survey dates: F	Sebruary 7, 8, and 9, 2012.			provider of any conclusion set forth in the statement of deficiencies, or of any violation		
	Facility number	. 000142			regulation. This provider		
	Provider number				respectfully requests that the F		
	AIM number: 10				of Correction be considered th		
	Anvi number. 10	00200940			Letter of Credible Allegation of after 03/01/2012.	n or	
	Survey Team:						
	Karina Gates, B	HS TC					
	Beth Walsh RN						
	Courtney Mujic	. RN					
	Barbara Hughes						
	Buroura rragnes	,, 10.					
	Census Bed Typ	oe:					
	SNF/NF: 90						
	Total: 90						
	10141.						
	Census Payor Ty	une:					
	Medicare: 11	ypc.					
	Medicaid: 67						
	Other: 12						
	Total: 90						
	Sample: 18						
		ies also reflect state accordance with 410 IAC					
	Quality review of	completed on February 15,					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

000142

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 03/05/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155237	B. WING		02/09/2012
		1		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	R		SHELBY ST	
BETHAN	IY VILLAGE NURS	ING HOME		NAPOLIS, IN 46227	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B	E COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	DATE
	2012 by Bev Fa	ulkner, RN			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HDFD11

Facility ID: 000142

If continuation sheet Page 2 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DDIG	00	COMPL	ETED
		155237	A. BUIL			02/09/	2012
			B. WING				
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE		
					SHELBY ST		
BETHAN	Y VILLAGE NURSII	NG HOME		INDIAN	APOLIS, IN 46227		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0225	The facility must n	ot employ individuals who					
SS=D	have been found g						
		treating residents by a					
	court of law; or ha	ve had a finding entered					
	into the State nurs	se aide registry concerning					
	•	istreatment of residents or					
		of their property; and report					
		nas of actions by a court of					
	-	ployee, which would					
		for service as a nurse aide					
		off to the State nurse aide					
	registry or licensin	ig authorities.					
	The facility must a	ensure that all alleged					
		g mistreatment, neglect, or					
		njuries of unknown source					
	•	ion of resident property are					
		tely to the administrator of					
	the facility and to						
	accordance with S						
		dures (including to the					
	•	certification agency).					
		ave evidence that all					
	alleged violations	• .					
		must prevent further					
	•	hile the investigation is in					
	progress.						
	The manufacture of the	ave atimatic as asset 5 -					
		nvestigations must be					
	reported to the add						
	-	entative and to other ance with State law					
		tate survey and certification					
	`	vorking days of the incident,					
	and if the alleged						
		ctive action must be taken.					
' <u> </u>		ew and record review, the	F022	25	F225 483.13(c)(1)(ii)-(iii), (c)(2) -	03/01/2012
			1 022		(4) INVESTIGATE/REPORT	,	03/01/2012
	_	ensure the supervisor and			ALLEGATIONS/INDIVIDUALS		
		ere notified immediately			The facility must not employ		
	of an allegation of	of verbal abuse and failed			individuals who have been fou	nd	

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Event ID: HDFD11

Facility ID: 000142

If continuation sheet Page 3 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPL	ETED
		155237	A. BUII			02/09/	/2012
		100207	B. WIN			02/00/	2012
NAME OF I	PROVIDER OR SUPPLIE	R		l	ADDRESS, CITY, STATE, ZIP CODE		
					SHELBY ST		
BETHAN	IY VILLAGE NURS	ING HOME		INDIAN	IAPOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	to report this all	egation to the Indiana			guilty of abusing, neglecting,		
	State Departmen	nt of Health within 24			mistreating residents by a cou		
	•	porting. The deficient			law; or have had a finding ent		
		d 1 of 3 residents reviewed			into the State nurse aide regis	stry	
	^				concerning abuse, neglect, mistreatment of residents or		
	_	tions of abuse in 3 facility			misappropriation of their prop	ertv:	
	_	tions reviewed for			and report any knowledge it h	•	
	implementation	of adequate abuse			of actions by a court of law		
	procedures. (Re	esident #32)			against an employee, which		
					would indicate unfitness for		
	Findings includ	e:			service as a nurse aide or oth	er	
					facility staff to the State nurse	;	
	On 2/7/12 at 10	:00 a.m., a report received			aide registry or licensing		
		State Department of Health			authorities. The facility must		
	-	_			ensure that all alleged violation		
		s reviewed. The report			involving mistreatment, negle		
	written on 10/11	1/11 by the Director of			or abuse, including injuries of		
	Nursing (DON)	, indicated 4 days earlier			unknown source and		
	on 10/7/11 at 7:	00 a.m., CNA #4 reported			misappropriation of resident property are reported immedia	ately	
	that Resident #3	32 was verbally abused by			to the administrator of the fac	•	
		days earlier, on 10/3/11			and to other officials in		
	` ′	N #5 was interviewed and			accordance with State law		
					through established procedur	es	
	suspended on 10	0///11 pending			(including to the State survey	and	
	investigation.				certification agency). The fac	cility	
					must have evidence that all		
	On 2/9/12 at 3:0	00 p.m., the administrator			alleged violations are thoroug	•	
		of information pertaining			investigated, and must prever		
		tion of the above incident.			further potential abuse while t		
	_				investigation is in progress. T		
		information was an			results of all investigations mube reported to the administrat		
		ent written by CNA #4 that			or his designated representat		
	was indicated to	have been given to the			and to other officials in	-	
	Memory Care C	Coordinator on 10/7/11			accordance with State law		
	around 7:00 a.m	n. The statement indicated			(including to the State survey	and	
		g the nurse (name of LPN			certification agency) within 5		
		get blood pressure on			working days of the incident,		
					if the alleged violation is verifi	ed	
	(name of Reside	ent #32) the resident was			appropriate corrective action		

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155237	B. WIN	G		02/09/2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
					SHELBY ST	
BETHAN	Y VILLAGE NURSI	NG HOME		INDIAN	APOLIS, IN 46227	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		hitting several times.			must be taken. What correct	
	When resident ra	ised hand to strike the			action(s) will be accomplishe for those residents found to	ea
	nurse (name of LPN #5) she told resident she would knock the s out of her."				have been affected by the	
					deficient practice? Residen	t
	Review of the do	ocumentation of the			#32 was followed by Memory	`
	telephone conversation that took place on 10/7/11 at 2:10 p.m., between LPN #5 and the DON and Administrator indicated				Care Coordinator (MCC) and	
					psychologist for any signs or	
					symptoms of distress. CNA	
		#5) returned call. Asked			was interviewed and re-educate	•
	`	·			on reporting criteria. · LPN #5 was interviewed, suspended a	•
		of any event that may			is no longer employed by this	iiu
		ith a resident on Memory			facility. · Allegation was report	ted
	Care (unit on wh				to Indiana State Department o	
	resided). She pa	used for a moment and			Health (ISDH) on 10/11/2011	
	said "No, not rea	llythe only thing she			How will you identify other	
	could think of wa	as (name of resident			residents having the potentia	ıl
	#32)She was h	itting and threatening to			to be affected by the same	
	kill me. She said	I that she was going to			deficient practice and what corrective action will be take	n2
		the CNA and she tried to			All resident have the potential	
	hit me " Asked i	f she could have said			be affected. Staff members	
		he paused again and we			report allegations of abuse to t	he
	1 -	d have said it using			supervisor and Administrator	
		guage. She said "No.			immediately. The	
					Administrator/Director of Nursi reports allegations of abuse to	
	· ·	ld her to cut that s			reports allegations of abuse to ISDH within 24 hours of	uic
		I shouldn't have said it			becoming aware of an allegation	on
		Discussed the meaning of			of abuse. What measures wi	•
		this not be construed as			be put into place or what	
	abuse. "I have n	ever abused any of my			systemic changes you will	
	residentsI have	never abused anyone			make to ensure that the	
	with Dementia o	r anyone." Asked if she			deficient practice does not	
	sees how using o	ffensive language could			recur? · The Executive Direct	or
		buse. I guess that it			(ED) inserviced Department Managers 02/22/2012 regardir	ng
		r would abuse anyone."			reporting criteria and timeline.	•
	Review of the do				Nursing staff was inserviced w	
		ceeding the telephone			posttest on or before 03/01/20	
	minieuratery proc	coding the telephone				

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Event ID: HDFD11

Facility ID: 000142

If continuation sheet Page 5 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED
		155237	B. WIN			02/09/2012
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	<u>t</u>			SHELBY ST	
	Y VILLAGE NURSI	NG HOME			APOLIS, IN 46227	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	•	DATE
		icated "Following the			by the ED/ Director of Nursing Services (DNS) regarding	
		ere unable to determine			reporting criteria and timeline t	to
	the correct version of what was said. We contacted (name of LPN #5) and informed				report. Inservices with postte	
					regarding Abuse are held in	
	her the investiga	tion was inconclusive and			orientation and no less than tw	
	she would be all	owed back at work with a			a year. · ED/Qualified Designo will interview staff members or	
	final written warning"				three shifts periodically to ensu	
					understanding about abuse an	
	Review of the tin	mecard for LPN #5			abuse reporting. How the	
	indicated she ret	urned to work that same			corrective action(s) will be	
	night of 10/7/11	at 10:53 p.m., and			monitored to ensure the	
	_	3 a.m. on 10/8/11.			deficient practice will not rec	ur,
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				i.e., what quality assurance program will be put into plac	02
	During interview	with the DON on 2/9/12			The DNS/Qualified Designee i	
	_	e indicated the reason the			responsible for the completion	
	results of the inv				the <i>Abuse Prohibition and</i>	
		•			Investigation Continuous Qual	-
		s because they tried not to			Improvement (CQI) tool weekl	y x
	· ·	e said". She indicated			4, bi-monthly x 2 months, and then quarterly x's 2 with results	
		terminated as a result of			reported to the CQI committee	
		ion/investigation, but was			overseen by the ED until	
		after because of her			determined during CQI meetin	
		indicated there was no			the audits are no longer requir	ed
	explanation as to	why this allegation was			based on a threshold of 100	
	not reported to the	ne Indiana State			percent. If threshold is not achieved an expanded action	
	Department of H	ealth timely.			plan will be developed to ensu	re
					compliance.	
	The "Abuse Prol	nibition Review" was				
	provided by the	DON on 2/9/12 at 2:30				
	1 ^	ed at this time. It				
	1 ^	4 was interviewed on				
		2/11, no times indicated.				
		n stated, "Yes, I gave you				
		sked why the delay in				
	*	•				
	reporting. Stated	I that at a previous job				

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Event ID: HDFD11

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If continuation sheet

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PRINTED: 03/05/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155237	A. BUILDING B. WING	00	COMP: 02/09			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S SHELBY ST INDIANAPOLIS, IN 46227					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROL DEFICIENCY)	ON BE PRIATE	(X5) COMPLETION DATE		
	REGULATORY OR she had reported then threatened a			CROSS-REFERENCED TO THE APPROL DEFICIENCY)	PRIATE			

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Event ID: HDFD11

Facility ID: 000142

If continuation sheet Page 7 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			IRVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLET	ΓED
		155237	A. BUII B. WIN			02/09/20	012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				SHELBY ST		
RETHΔN	Y VILLAGE NURSII	NG HOME			APOLIS, IN 46227		
					,		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCE		DATE
F0226		evelop and implement d procedures that prohibit					
SS=D	•	·					
	mistreatment, neglect, and abuse of residents and misappropriation of resident						
	property.	2PP. 0P. 1410 0. 100.40					
'	Based on interview and record review, the		F02	26	F226 483.13(c)) (03/01/2012
	facility failed to	ensure the supervisor and			DEVELOP/IMPLMENT,		
	Administrator we	ere notified immediately			ABUSE/NEGLECT, ETC POLICIES The facility must		
	of an allegation of	of verbal abuse per			develop and implement writter	,	
	facility policy an	d failed to report this			policies and procedures that		
		Indiana State Department			prohibit mistreatment, neglect,		
	of Health within 24 hours of staff				and abuse of residents and		
	reporting per fac				misappropriation of resident property. What corrective		
		e affected 1 of 3 residents			action(s) will be accomplished		
	•	to allegations of abuse in			for those residents found to		
		nvestigations reviewed			have been affected by the		
	_	on of adequate abuse			deficient practice? Resident		
	-	-			#32 was followed by Memory		
	procedures. (Res	sident #32)			Care Coordinator (MCC) and		
	Eindings in aluda				psychologist for any signs or symptoms of distress. · CNA	_{#4}	
	Findings include	•			was interviewed and educated		
	On 2/7/12 at 10:0	00 a.m., a report received			reporting criteria. · LPN #5 wa		
		-			interviewed, suspended and is		
	-	ate Department of Health			longer employed by this facility		
		reviewed. The report			Allegation was reported to Indi	ana	
		11 by the Director of			State Department of Health (ISDH) on 10/11/2011 How w	vill	
		indicated 4 days earlier			you identify other residents	····	
		0 a.m., CNA #4 reported			having the potential to be		
		2 was verbally abused by			affected by the same deficier	nt	
	LPN #5 four (4)	days earlier, on 10/3/11			practice and what corrective		
	at 3:30 a.m. LPN	N #5 was interviewed and			action will be taken? All		
	suspended on 10	/7/11 pending			resident have the potential to be		
	investigation.				affected. · Staff members reposite allegations of abuse to the	ort	
	_				supervisor and Administrator		
	On 2/9/12 at 3:00	p.m., the administrator			immediately. • The		
		of information pertaining			Administrator/Director of Nursi	ng	
	provided a copy	or information pertaining			reports allegations of abuse to	the	

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Event ID: HDFD11

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If continuation sheet Page 8 of 24

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	LDING	00	COMPLETED
		155237	B. WIN			02/09/2012
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER				SHELBY ST	
RETHΔN	Y VILLAGE NURSI	NG HOME			APOLIS, IN 46227	
			_		711 OLIO, 114 40227	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG		DATE
	_	on of the above incident.			ISDH within 24 hours of staff	:11
	Included in the information was an				reporting. What measures w be put into place or what	111
	undated statemer	nt written by CNA #4 that			systemic changes you will	
	was indicated to	have been given to the			make to ensure that the	
	Memory Care Co	pordinator on 10/7/11			deficient practice does not	
	<u> </u>	The statement indicated			recur? The Executive Director	or
		the nurse (name of LPN			(ED) reviewed the ABUSE	
	_	•			PROHIBITION, REPORTING,	
	' ' '	et blood pressure on			AND INVESTIGATION POLIC	Y
	`	nt #32) the resident was			AND PROCEDURE then	
		hitting several times.			inserviced Department Manag	
	When resident ra	ised hand to strike the			02/22/2012 regarding reporting criteria and timeline. Staff]
	nurse (name of I	LPN #5) she told resident			members were inserviced with	
	she would knock	the s out of her."			posttest on or before 03/01/20	
	Review of the do	ocumentation of the			by the ED/ Director of Nursing	
		rsation that took place on			Services (DNS) regarding	
	•	o.m., between LPN #5			ABUSE PROHIBITION,	
	_	d Administrator indicated			REPORTING, AND	
					INVESTIGATION POLICY AND	
	· ·	#5) returned call. Asked			PROCEDURE. Inservices w	
		of any event that may			posttest regarding Abuse are he in orientation and no less than	ı
	have occurred w	ith a resident on Memory			twice a year. · ED/Qualified	
	Care (unit on wh	ich Resident #32			Designee will interview staff	
	resided). She pa	used for a moment and			members on all three shifts	
	said "No, not rea	llythe only thing she			periodically to ensure	
	· ·	as (name of resident			understanding about abuse an	ıd
		itting and threatening to			abuse reporting. How the	
	·	I that she was going to			corrective action(s) will be	
		the CNA and she tried to			monitored to ensure the	
					deficient practice will not rec	ur,
		f she could have said			i.e., what quality assurance program will be put into plac	02
		he paused again and we			The DNS/Qualified Designee i	
		d have said it using			responsible for the completion	
	inappropriate lan	guage. She said "No.			the Abuse Prohibition and	
	Well, I think I to	ld her to cut that s			Investigation Continuous Qual	ity
	· ·	I shouldn't have said it			Improvement (CQI) tool weekl	y x
		Discussed the meaning of			4, bi-monthly x 2 months, and	
	una i icci baa.	Discussed the incaming of			then quarterly x's 2 with results	s

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Event ID: HDFD11

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155237		A. BUILDING B. WING O COMPLETED 02/09/2012			ETED		
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				SHELBY ST		
	Y VILLAGE NURSI				APOLIS, IN 46227		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
IAG		this not be construed as		IAG	reported to the CQI committee		DATE
		ever abused any of my			overseen by the ED until		
	residentsI have never abused anyone			determined during CQI meeting			
		r anyone." Asked if she			the audits are no longer require based on a threshold of 100	ed	
		ffensive language could			percent. If threshold is not		
	_	buse. I guess that it		achieved an expanded action			
		r would abuse anyone."			plan will be developed to ensu	re	
	Review of the do	-			compliance.		
	immediately prod	ceeding the telephone					
	conversation indi	cated "Following the					
	interviews we we	ere unable to determine					
	the correct version	on of what was said. We					
	contacted (name	of LPN #5) and informed					
	her the investigat	ion was inconclusive and					
	she would be allo	owed back at work with a					
	final written warı	ning"					
		necard for LPN #5					
		irned to work that same					
	_	at 10:53 p.m. and worked					
	until 8:13 a.m. or	n 10/8/11.					
	_	with the DON on 2/9/12					
	•	e indicated the reason the					
	results of the inve						
		because they tried not to					
	· ·	e said". She indicated					
		terminated as a result of					
	_	ion/investigation, but was					
		after because of her					
		indicated there was no					
		why this allegation was					
	not reported to th						
	Department of H	earm umery.					

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Event ID: HDFD11

Facility ID: 000142

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PRINTED: 03/05/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 155237	(X2) MULTIPLE COI A. BUILDING B. WING	00 	COMPLETED 02/09/2012
	PROVIDER OR SUPPLIER Y VILLAGE NURSING HOME	3518 S	DDRESS, CITY, STATE, ZIP CODE SHELBY ST APOLIS, IN 46227	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
	The "Abuse Prohibition Review" was provided by the DON on 2/9/12 at 2:30 p.m., and reviewed at this time. It indicated CNA #4 was interviewed on 10/7/11 and 10/12/11, no times indicated. The notes section stated, "Yes, I gave you my statement. Asked why the delay in reporting. Stated that at a previous job she had reported someone and that person then threatened and stalked her. "I was afraid, but I knew that I couldn't let it go."" The facility's abuse policy was provided by the Administrator on 2/7/12 at 11:00 a.m. The policy indicated, "All allegations/abuse must be reported to the Executive Director immediatelyIt is the responsibility of the Administrator/DON to report the abuse, or allegations of abuse, within 24 hours to the Indiana State Department of HealthAny individual who witnesses abuse, or has suspicion of, shall immediately notify the charge nurse of the unit, which the resident resides." 3.1-28(a)			

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Event ID: HDFD11

Facility ID: 000142

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIM D	D.C.	00	COMPL	ETED
		155237	A. BUILD	ING		02/09/	/2012
			B. WING	CED FEE	DDDEGG GITW GTATE JID GODE		
NAME OF F	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
					SHELBY ST		
BETHAN	Y VILLAGE NURS	ING HOME		INDIAN	APOLIS, IN 46227		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLA			(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PI	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0282	The services prov	vided or arranged by the		ĺ			
SS=D		ovided by qualified persons					
		h each resident's written					
]	plan of care.		ļ	ļ			
	Based on observ	vation, interview, and	F0282	2	F282 483.20(k)(3)(ii) SERVICI		03/01/2012
	record review, tl	he facility failed to follow			BY QUALIFIED PERSONS/PE	=R	
	physician's orders for 1 of 8 residents				CARE PLAN The services provided or arranged by the		
		completion and 1 of 1			facility must be provided by		
		red for splint application,			qualified persons in accordance	e	
		e of 18 (#79, #52).			with each resident's written pla		
	iii a totai sairipie	5 01 18 (#79, #32).			of care. What corrective		
					action(s) will be accomplished	ed	
	Findings include:				for those residents found to		
					have been affected by the		
	1. The clinical	record for Resident #79			deficient practice? · Residen		
	was reviewed or	n 2/7/12 at 1:30 p.m.			#79 was screened by therapy	for	
					appropriate splint application,		
	The diagnoses f	or Resident #79 included,			physician was notified, care pl		
	_	·			and CNA assignment sheets a updated. Resident #52's	are	
		nited to: osteoporosis,			physician was notified and BM	ID	
		nt disease, osteoarthritis,			drawn on 02/09/2012 and	"	
	and history of le	off knee and left hip			02/16/2012 with results reporte	ed	
	replacement.				to physician. How will you		
					identify other residents having	ng	
	A recapitulation	of the February			the potential to be affected b	y	
	•	ers indicated that bilateral			the same deficient practice a	nd	
	,				what corrective action will be	•	
	•	ts were to be on while in			taken? · Residents who wear		
	bed.				splints have the potential to be		
					affected. · Resident's who we		
	There was a clar	rification of the above			splints were screened by there	ару	
	order on 2/8/12	that indicated boots were			and wear splints based on		
	to be on while in				physician orders. Care plans	anu	
	to be on while if				CNA assignment sheets are updated. Residents with		
	A 1 1	. 1.1/4/10 Coming 1			laboratory orders have the		
	-	ed 1/4/12, for impaired			potential to be affected.		
	skin integrity ha	d an approach for the use			Residents with laboratory orde	ers	
	of foot splints, to	o help the resident's			have labs drawn based on	=	
	wounds be free	from signs of			physician orders What		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			COMPLETED
		155237				02/09/2012
			B. WIN		ADDRESS SITY STATE ZIR CODE	
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP CODE	
					SHELBY ST	
BETHANY VILLAGE NURSING HOME			INDIAN	IAPOLIS, IN 46227		
(X4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	complications.				measures will be put into pla	ce
	•				or what systemic changes yo	ou
	During on observ	vation on 2/8/12 at 2:30			will make to ensure that the	
	_				deficient practice does not	
	*	t was asleep in bed with			recur? The Director of Nursi	•
	•	e the bed. LPN #2			(DNS) inserviced with posttest	
	indicated the res	ident is to have the			nursing staff on or before	
	splints on while	in bed. She indicated the			03/01/2012 regarding splint	
	-	taken off and will only			application and referencing	
		hour, since the resident			Resident Care Sheets. Nursiverify splint placement on nurs	
		*			rounds. Nurse Managers	sirig
		ne splints and seemed			reviewed all routine lab draw	
	irritated by the sp	plints.		orders and verified that they are		
				on the laboratory draw schedule.		
	During an observ	vation on 2/8/12 at 3:50		· Assistant Director of Nursing		
	p.m., the residen	t was asleep in bed with		(ADNS) reviewed and recorded		
	the splints beside	-			next lab draw dates on lab	
	the spinits design	cure oca.			tracking form. · New lab order	
	D ' 1	.: 2/9/12 + 4.20			are reviewed by nurse manage	ers
		vation on 2/8/12 at 4:30			in the Interdisciplinary Team	
	•	PN #1, the resident was			meeting at which time it is veri	
	asleep in bed wit	th the splints beside the			that new labs are ordered and confirmed that results are	/or
	bed. LPN #1 inc	licated that the splints			received. · Nurses were	
	were to be on wh	nile the resident is in bed			inserviced on 02/16/2012 by	
		ceeded to put the splints			laboratory account manager o	n l
	on the resident.	ceded to put the spinits			ordering labs and obtaining	
	on the resident.				results. How the corrective	
					action(s) will be monitored to	
		ecord for Resident #52			ensure the deficient practice	
	was reviewed 2/8	8/12 at 11:55 a.m.			will not recur, i.e., what quali	ty
					assurance program will be p	ut
	The diagnoses for	or Resident #52 included,			into place? The DNS/Qualifie	
	_	ited to: diabetes mellitus,			Designee is responsible for the	e
					completion of the Splints and	
	•	nyelitis, wounds, and			Labs/Diagnostics Continuous	,
	septicemia.				Quality Improvement (CQI) too	DI
					weekly x 4, bi-monthly x 2	,
	A recapitulation	of the physician's orders			months, and then quarterly x's with results reported to the CG	
	indicated that an	order was written on			committee overseen by the FI	

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	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER: 155237	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/09/2012
	PROVIDER OR SUPPLIER Y VILLAGE NURSING HOME	3518 S	ADDRESS, CITY, STATE, ZIP CODE SHELBY ST JAPOLIS, IN 46227	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	l `		until determined during CQI meeting the audits are no lon required based on a threshold 100 percent. If threshold is n achieved an expanded action plan will be developed to ens compliance.	ger d of ot

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
		155237	B. WIN			02/09/	2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				SHELBY ST		
BETHAN	Y VILLAGE NURSII	NG HOME			APOLIS, IN 46227		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0322 SS=D	a resident, the factoresident who is feet gastrostomy tube to treatment and service pneumonia, diarrh metabolic abnormanasal-pharyngeal possible, normal elemanterview, the factoresident was possible for the additional possible.	ulcers and to restore, if sating skills. ation, record review and cility failed to ensure a stioned at the correct bed ministration of medicines	F03	22	F322 483.25(g)(2) NG TREATMENT/SERVICES -RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the		03/01/2012
	resident requiring sample of 18. (R	:			facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tu receives the appropriate treatment and services to prev aspiration pneumonia, diarrhed vomiting, dehydration, metabo abnormalities, and	ent a,	
	_	vation on 2/8/12 at 4:05 ministered medications			nasal-pharyngeal ulcers and to		
	· ·	by feeding tube) with the			restore, if possible, normal eat skills. What corrective action		
	,	lower than 30 degrees			will be accomplished for thos		
	•	<u> </u>			residents found to have been		
	` .	hysician's order). The			affected by the deficient		
	During an intervi	iew at 4:10 P.M., LPN #3 ident does cough and gag was not unusual			practice? Resident #85 hea of bed elevation was recalibrated by Maintenance Director to ensure proper elevation. LPI #3 was re-educated on how to determine the proper bed height	ted N	
	bottom of the bed was observed to	bserved on the bed and also on the d frame. The bed frame be approximately 6 in the black tape on the			Speech therapy evaluated Resident #85 due to concerns over gagging and coughing during medication administration It was determined that residen has oral and pharyngeal dysphagia and safely receives nutrition/hydration from GT.	on. t	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPL	ETED
		155237	A. BUI B. WIN			02/09/	2012
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	NAME OF PROVIDER OR SUPPLIER						
DETIIAN	VVIII ACE NUIDO	NC HOME			SHELBY ST		
DETHAN	Y VILLAGE NURSI	ING HOME		INDIAN	APOLIS, IN 46227		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					How will you identify other		
	Review of Resid	dent 85's record on 2/9/12			residents having the potentia	al	
	did not indicate	any episodes of coughing			to be affected by the same		
		sident #85's current			deficient practice and what		
					corrective action will be take	n?	
	~	led but were not limited			· Resident's requiring		
		, quadriplegia, aphasia			gastrostomy tube (GT) feeding and GT medication have the	js	
	and dysphagia.				potential to be affected.		
					Resident's requiring GT feedir	nas	
	A Physician's or	der, dated 2/1/12,			and GT medication receive the		
		esident #85's bed should			appropriate treatment per		
		o 45 degrees for the			physician order and services to	0	
	administration o	•			prevent complications. What		
		i medications.			measures will be put into pla	ce	
					or what systemic changes yo	ou	
	On 2/9/12 at 2:0	0 P.M., during an			will make to ensure that the		
	interview, the A	DON indicated that the			deficient practice does not		
	black tape on the	e headboard of the			recur? GT resident beds we		
		ould line up with the			remarked using a narrower mo		
		e bed frame. If the tape			easily identifiable tape. • The		
		, the bed was in a			Director of Nursing (DNS) ordered 10 inclinators on		
	_				02/17/2012 with anticipated		
	^	nan 30 degrees, as			delivery of 02/23/2012.		
		lication administration.			Maintenance Director to apply		
	The ADON indi	cated she would conduct			inclinators to beds. · DNS		
	training to staff	about the tape indications			inserviced staff with posttest o		
		eight of 30 degrees.			before 03/01/2012 regarding h	IOW	
	r r - r	. 8			to identify 30° based on tape		
	3.1-44(a)(2)				markings on the head of bed.		
	[3.1-44(a)(2)]				Reinservicing regarding the us		
					of the inclinator will be comple	tea	
					prior to installation. · Nurses verify head of bed elevation		
					during rounds. How the		
					corrective action(s) will be		
					monitored to ensure the		
					deficient practice will not rec	ur.	
					i.e., what quality assurance	1	
					program will be put into plac	e?	

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	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CC		COMPL	
ANDILAN	OI CORRECTION	155237	A. BUILDING	00	02/09/	
		100201	B. WING	ADDRESS SITV STATE ZID SORE	02/03/	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE SHELBY ST		
	Y VILLAGE NURSI		INDIAN	APOLIS, IN 46227		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO! (EACH CORRECTIVE ACTION SHOULD E	N DE	(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	COMPLETION DATE
1100	REGULATORT OR	ESC IDEATH THAT IN ONWATION)		The DNS/Qualified Designeresponsible for the completion the Enteral Therapy Continuality Improvement (CQI) weekly x 4, bi-monthly x 2 months, and then quarterly with results reported to the committee overseen by the until determined during CQI meeting the audits are no loo required based on a threshof 100 percent. If threshold is achieved an expanded action plan will be developed to encompliance.	e is on of uous tool x's 2 CQI ED onger old of not	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETE				
		155237	B. WIN	G		02/09/	2012
NAME OF P	ROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	ROVIDER OR SOLI ELER				SHELBY ST		
BETHAN	Y VILLAGE NURSII	NG HOME		INDIAN	IAPOLIS, IN 46227		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)	1	DATE
F0412 SS=D	The nursing facility from an outside re §483.75(h) of this covered under the emergency dental needs of each resi assist the resident and by arranging f from the dentist's crefer residents with to a dentist. Based on observational facility failed to a missing dentures follow-up dental affected 1 of 1 redental care in the #82) Findings include On 2/9/12 at 2:20 interviewed and in missing her bottom requesting new to facility for a long been done. She is regular diet and scan." During an interviewed Services Director P.M., the ADON	y must provide or obtain source, in accordance with part, routine (to the extent State plan); and services to meet the ident; must, if necessary, in making appointments; for transportation to and office; and must promptly in lost or damaged dentures ation and interview, the ensure a resident with had been scheduled for a appointment. This esident reviewed for a sample of 18. (Resident	F04		F412 483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS 7 nursing facility must provide or obtain from an outside resource in accordance with §483.75(h) this part, routine (to the extent covered under the State plan); and emergency dental services meet the needs of each reside must, if necessary, assist the resident in making appointment and by arranging for transportation to and from the dentist's office; and must promptly refer residents with 1c or damaged dentures to a den What corrective action(s) with be accomplished for those residents found to have been affected by the deficient practice? Resident #82 was seen by the dentist on 02/14/2 to start the process for lower denture replacement. Speech therapy screened resident on 02/21/2012 and stated that resident has no difficulty with eating. Resident had impressi	ee, of s to nt; ost tist. iii	03/01/2012
	•	ation from the facility's			made 02/21/2012. How will y identify other residents havir		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPLETED
		155237	B. WIN			02/09/2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER				SHELBY ST	
DETUAN		NC HOME				
BETHAN	Y VILLAGE NURSII	NG HOME		INDIAN	APOLIS, IN 46227	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	computer indicat	ing that Resident #82			the potential to be affected by	y
	•	ntist on 3/18/11 who			the same deficient practice a	nd
	_	ident needed new			what corrective action will be	,
					taken? · Residents with lost o	r
	dentures consisti	ng of both the upper and			damaged dentures have the	
	lower plates. Th	e SSD also indicated she			potential to be affected.	
	could not find an	y other record of the			Residents with lost or damage	d
		nade or delivered.			dentures are promptly referred	to
	dentares semig in	add of defivered.			a dentist. What measures wi	II
					be put into place or what	
		0 P.M., the SSD was			systemic changes you will	
	observed viewing	g Resident #82's mouth			make to ensure that the	
	and indicated she	e did not see any lower			deficient practice does not	
	plate dentures.	3			recur? Social Services set up)
	place deficates.				two alternative dentists that ha	ve
					agreed to see any of our	
	During an intervi	iew with the SSD on			residents who require emerger	-
	2/9/12 at 3:30 P.I	M., she indicated she had			dental services. · Residents w	rith
	done some resear	rch and found that the			dentures were assessed for	
	resident did not k	nave any insurance in			presence and fit of dentures.	
	effect until 10/1/	•			Residents with missing or ill fitt	~
					dentures were referred to Soci	aı
		been scheduled for her			Services to set up dental	
	to have impression	ons made for dentures on			services. Dentist is here	
	11/9/11, but that	Resident #82 was out of			02/23/2012. Resident Care sheets reflect denture use.	
	· ·	at day and that nothing			Certified Nursing Assistants	
	has been done sin				report when dentures are lost of	or
	nas occii done sii	nee mat time.			damaged. How the corrective	l l
					action(s) will be monitored to	l l
	3.1-24(a)(3)				ensure the deficient practice	
					will not recur, i.e., what qualit	
					assurance program will be pu	-
					into place? The DNS/Qualified	l l
					Designee is responsible for the	l l
					completion of the Dental Servi	
					Continuous Quality Improvement	
					(CQI) tool weekly x 4, bi-month	
					x 2 months, and then quarterly	-
					2 with results reported to the C	
					committee overseen by the ED	
					until determined during CQI	

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	OF CORRECTION	IDENTIFICATION NUMBER: 155237	(X2) MULTIPLE CO A. BUILDING B. WING	00 	COMPLETED 02/09/2012
	PROVIDER OR SUPPLIE Y VILLAGE NURS		3518 S	ADDRESS, CITY, STATE, ZIP CODE SHELBY ST IAPOLIS, IN 46227	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
IAG	REGULATORY OF	CLSC IDENTIFYING INFORMATION)	TAG	meeting the audits are no lon required based on a threshold 100 percent. If threshold is n achieved an expanded action plan will be developed to enscompliance.	ger d of ot

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155237	B. WING		02/09/2012
	PROVIDER OR SUPPLIE		3518 9	ADDRESS, CITY, STATE, ZIP CODE S SHELBY ST NAPOLIS, IN 46227	
(X4) ID	X4) ID SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0496 SS=D	nurse aide, a faci verification that the competency evaluation progra approved by the sprove that he or successfully competency evaluation progra evaluation evalua	pleted a training and pation program or pation program approved by a not yet been included in lities must follow up to an individual actually ed. In individual to serve as a lity must seek information registry established under 2)(A) or 1919(e)(2)(A) of a believes will include a individual. Itual's most recent alining and competency m, there has been a lof 24 consecutive months which the individual provided grelated services for insation, the individual must raining and competency m or a new competency m. The service of the individual must raining and competency m or a new competency m. The service of the individual must raining and competency m. The service of the individual must raining and competency m. The service of the individual must raining and competency m. The service of the service of the individual must raining and competency m.	F0496	F496 483.75(e)(5)-(7) NURSE	03/01/2012
	facility failed to was working as 2011, was regist	ensure an employee who a nurse aide since May, ered with the Indiana at of Health as a nurse		AIDE REGISTRY VERIFICATION, RETRAINING Before allowing an individual t serve as a nurse aide, a facilit must receive registry verificati that the individual has met competency evaluation requirements unless the	o y

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155237	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE COMPI 02/09.	ETED
	PROVIDER OR SUPPLIER Y VILLAGE NURSING HOME	STREET ADDRESS, CITY 3518 S SHELBY ST INDIANAPOLIS, IN	Г	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORE CROSS-REFE	DER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: The employee record for Employee #6 was reviewed on 2/9/12 at 11:30 a.m. The records indicated her job position was a CNA (Certified Nurse Aide), but no license could be found in the employee's file. During an interview with the Executive Director on 2/9/12 at 1:25 p.m., he indicated Employee #6 did not pay the fee to take the state test to become a CNA and is not on the state's registry. He indicated Employee #6 began working as a CNA in May, 2011. 3.1-14(e)(2)	in a training evaluation the State; of prove that successful and compete program of evaluation the State as included in must follow such an included information registry est sections 18 1919(e)(2) facility belia information since an incompletion competence there has be period of 2 during non individual properties in monetary of individual properties in training an evaluation competence what correspond to the accompetence with the properties affected by practice? immediate	s a full-time employee g and competency program approved by or the individual can he or she has recently ly completed a training etency evaluation recompetency program approved by and has not yet been the registry. Facilities wup to ensure that dividual actually egistered. Before individual to serve as de, a facility must seek in from every State tablished under 819(e) (2)(A) or (A) of the Act the eves will include in on the individual. If, individual's most recent in of a training and ey evaluation program, been a continuous 4 consecutive months e of which the provided nursing or ated services for compensation, the must complete a new do competency program or a new ey evaluation program. Bective action(s) will plished for those found to have been by the deficient the Employee #6 was by removed from the hedule. How will you	

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	IDENTIFICATION NUMBER: 155237 A. BUILDING B. WING		00	COMPLETED 02/09/2012	
	ROVIDER OR SUPPLIER		3518 S	ADDRESS, CITY, STATE, ZIP CODE SHELBY ST JAPOLIS, IN 46227	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
				identify other residents having the potential to be affected by the same deficient practice as what corrective action will be taken? Residents requiring nursing care have the potential be affected. All Certified Nursing Assistance (CNA) have current certification. What measures will be put into plator what systemic changes you will make to ensure that the deficient practice does not recur? Nursing Scheduler diffull audit for all CNAs and certifications are current and present. Home Office consultant reviewed and verifications are consistently maintained and current. Nursing scheduler to establish system to ensure certifications are consistently maintained and current. Nursing schedule keeps the CNA certifications are consistently maintained and current. Nursing schedule keeps the CNA certification in a binder arranged by month; the certifications are reviewed prior to the 1 st of each month to remind CNA of the date for their recertification. The date is recorded on a monthly calendar that is checked daily. CNAs are promptly removed from the schedule verification of current certification is not received prior to the required date. He the corrective action(s) will the monitored to ensure the	e al to ve ace ou d a a a a a a a a a a a a a a a a a a

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155237	A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE	COMPLETED 02/09/2012
NAME OF PROVIDER OR SUPPLIER BETHANY VILLAGE NURSING HOME	3518 S SHELBY ST INDIANAPOLIS, IN 46227	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
	deficient practice will not re i.e., what quality assurance program will be put into plath The DNS/Qualified Designer responsible for the completion the <i>Employee Files</i> Continuous Quality Improvement (CQI) to weekly x 4, bi-monthly x 2 months, and then quarterly x with results reported to the Committee overseen by the Euntil determined during CQI meeting the audits are no low required based on a threshod 100 percent. If threshold is a achieved an action plan may developed to ensure compliance to the compliance of the complete that is a chieved an action plan may developed to ensure compliance.	e is on of ous ool est 2 CQI ED ager Id of ont of observed be

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